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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **ANDREW JOSEPH PATTERSON,** **aka ANDREW J. PATTERSON** **606 S. Waterview** **Richardson, TX 75080** **Registered Nurse License No. 758840** Respondent.	Case No. 2013-221 **FIRST AMENDED** **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 27, 2009, the Board issued Registered Nurse License Number 758840 to Andrew Joseph Patterson, also known as Andrew J. Patterson ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein, expired on November 30, 2012, and has not been renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 states, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

COST RECOVERY

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Disciplinary Action by the Arizona State Board of Nursing)

7. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that he was disciplined by the

Arizona State Board of Nursing ("Arizona Board") and the Tennessee Board of Nursing ("Tennessee Board") as follows:

A. On or about November 14, 2011, pursuant to Consent Agreement and Order No. 0910124 in the disciplinary proceeding titled "In the Matter of the Privilege to Practice Nursing Under the Nurse Licensure Compact in the State of Arizona Issued to: Andrew J. Patterson", the Arizona Board revoked Respondent's multi-state privilege to practice as a professional nurse in the state of Arizona. The Board further ordered that the revocation would be stayed as long as Respondent remained in compliance with certain terms and conditions, and that Respondent's privilege would be suspended for a period not to exceed 12 months pending resolution of the Tennessee Board of Nursing's disciplinary proceedings against Respondent's Registered Nurse License No. RN160122 (issued by the Tennessee Board). A true and correct copy of Consent Agreement and Order No. 0910124 is attached as Exhibit A and incorporated herein. Respondent admitted the following Findings of Fact.

i. On or about October 29, 2009, the Arizona Board received a complaint from the Vice Chairperson of Nursing Services at Mayo Clinic, alleging that on or about October 26, 2009, Respondent exhibited impaired judgment/behavior/substandard nursing practice; failed to administer ordered medications; and accessed the Pyxis machine for medications that were not ordered for his patients. Respondent admitted that he was recently in rehabilitation and refused drug testing, resulting in the termination of his contract at Mayo Clinic Hospital ("MCH"). Based on the complaint, the Board conducted an investigation and found as follows:

ii. In and between June 2007 and April 2009, Respondent was employed by Health Providers Choice and was assigned to work at MCH in Arizona from October 6, 2009, to October 26, 2009.

iii. Respondent was scheduled to work the night shift beginning at 7:00 p.m. on October 18, 2009, and ending at 7:00 a.m. on October 19, 2009, at MCH and was responsible for the care of patient F.A.

(a). On October 18, 2009, Respondent removed a Metoprolol Tartrate 5 mg/5 ml vial from the Pyxis for patient F.A. at 2123 and returned the medication to the Pyxis at 2124.

(b). On October 18, 2009, Respondent removed a Metoprolol Tartrate 50 mg tablet from the Pyxis for patient F.A. at 2125 and returned the medication to the Pyxis at 2129.

(c). According to the Pyxis report, at 2129, Respondent returned to the Pyxis a Metoprolol Tartrate 5 mg/5 ml vial that was documented as given by Fang-Min Liao at 1707.

(d). According to the Pyxis report, Respondent removed a Metoprolol Tartrate 5 mg/5 ml vial at 2130. Respondent documented Metoprolol 5 mg IV as given at 2125.

(e). According to the Medication Administration Record, Respondent documented giving Metoprolol Tartrate 50 mg PO at 2126. According to the Pyxis report, Respondent did not remove this medication from the Pyxis.

iv. Respondent was scheduled to work the night shift beginning at 7:00 p.m. on October 25, 2009, and ending at 7:00 a.m. on October 26, 2009, at MCH, and was responsible for the care of patient E.S.

(a). On October 25, 2009, Respondent documented performing an assessment for patient E.S. at 2333. Respondent failed to document any care on the required flow sheets ("FS"), including the Education FS, Central Cath Line FS and Patient Care Activities FS. The nurses prior to and following Respondent both documented care provided on the flow sheets.

(b). On October 25, 2009, patient E.S. was scheduled to receive Rifaxamin 400 mg PO at 2200 and Hydrocortisone Succinate 50 mg IV at 2200. Respondent failed to administer either medication. The Pyxis report indicated that the medications were not removed from the Pyxis.

(c). On October 25, 2009, according to the Pyxis report, Respondent removed a Phenylephrine HCL 10 mg vial for patient E.S. at 2247 when there was no physician's order for the medication. Respondent failed to account for the medication by either documenting administration or returning the medication to the Pyxis.

(d). On October 25, 2009, patient E.S. was scheduled to receive Meropenem 1 mg IV at 2100. Although the medication was documented as given, Respondent hung fluconazole at 2100 instead of Meropenem, in error.

(e). On October 26, 2009, at approximately 0330, Hollie Thornton, RN, observed a bag of fluconazole hanging for patient E.S. that was not due to be administered until 0900. Thornton

also found the Meropenem had not been administered on October 25, 2009, at 2100 as ordered. According to Thornton and Respondent's documentation, Respondent administered the Meropenem on October 26, 2009, at 0345.

v. Michelle Anderson, RN, provided a written statement regarding her interaction with Respondent on or about October 26, 2009. Anderson met with Respondent in her office at approximately 4:30 a.m. (Anderson had been called at home by the ICU Team Leader, who reported that Respondent was "unable to articulate a full sentence" and had not documented or administered various medications). Anderson noted, among other things, that Respondent had rapid eye movements, his sentences were poorly structured, and he did not make sense during their conversation. Respondent denied being under the influence of drugs or alcohol, but allegedly admitted that he had just been in a rehabilitation facility, "Sober Living", for three months. Respondent refused to submit to a urine drug screen, stating that he would have one done outside of the facility. Respondent failed to do so.

vi. Debbie Sheppard, RN, the ICU Team Leader, provided a written statement regarding her interaction with Respondent on or about October 26, 2009. Sheppard reported that Respondent had halting speech, was unable to put a complete sentence together, and was "flighty" and "paranoid". Respondent told Sheppard that "People are standing outside my room and talking about me" when no one was present. Further investigation revealed that on October 25, 2009, Respondent had neither pulled nor charted medications due at 2100 and 2200.

vii. Cindy McLane, RN, provided a written statement regarding her interaction with Respondent on or about October 26, 2009. McLane reported that Respondent told her, "I hate it when the gremlins are watching me." During an interview with Board staff on or about April 22, 2010, McLane stated that Respondent appeared "high" and had made a comment that "there are gremlins on the wall."

viii. During an interview with Board staff on or about April 26, 2010, Rosemarie Torrento, CEO of Health Providers Choice, reported that she spoke to Respondent by telephone on or about October 27, 2009. Respondent was "talking crazy" and was incoherent during the conversation. Torrento called Respondent later in the day and found him more lucid. Respondent admitted to

Torrento that he had "fallen off the wagon" and was currently living in a halfway house. When asked to submit to a urine drug screen, Respondent refused, stating that the test would be positive. Respondent also admitted to Torrento that he did not give medications to his assigned patients as ordered.

ix. Hollie Thornton provided a written statement regarding her interaction with Respondent on or about October 26, 2009. At approximately 0330, Thornton found Respondent looking back and forth down the hall from a patient's room. When asked if he needed help, Respondent replied that he needed a "pharmacy bag" to send back a medication that had not been ordered for his patient. Upon further questioning, Respondent had trouble staying focused and needed redirection and instruction to pull up orders and charts on the computer. Thornton later discovered that Respondent had not charted several medications.

x. During the course of the Board's investigation, it was discovered that Respondent had been employed at Memorial Hospital in Chattanooga, Tennessee, from June 13, 2005, until April 17, 2009, and had been terminated from his employment for sleeping on the job.

B. On or about August 30, 2012, pursuant to an Agreed Order, in Docket No. 17.19-117450A in the disciplinary proceeding titled "In the Matter of Andrew J. Patterson, R.N. License No. 160122", the Tennessee Board revoked Respondent's Tennessee nursing license and voided Respondent's multi-state privilege to practice as a professional nurse in any other state. The Board further ordered that the revocation would be stayed and the Respondent's license was placed on suspension for 180 days while Respondent complied with certain terms and conditions. A true and correct copy of the Agreed Order, Docket No. 17.19-117450A is attached as Exhibit B and incorporated herein. As a basis for discipline, Respondent admitted to the Arizona Board's discipline and basis therefore.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 758840, issued to Andrew Joseph Patterson, also known as Andrew J. Patterson;

2. Ordering Andrew Joseph Patterson, also known as Andrew J. Patterson, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 10, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2012105843

EXHIBIT A

Consent Agreement and Order No. 0910124

BEFORE THE ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF THE PRIVILEGE TO PRACTICE NURSING UNDER THE NURSE LICENSURE COMPACT IN THE STATE OF ARIZONA ISSUED TO: ANDREW J. PATTERSON, RESPONDENT REGISTERED NURSE LICENSE NO. RN160122 STATE OF TENNESSEE	CONSENT AGREEMENT AND ORDER NO. 0910124

CONSENT AGREEMENT

A complaint charging Andrew J. Patterson ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements and the responsibilities of the Board, and pursuant to A.R.S. § 41-1092.07(F)(5) and the Nurse Licensure Compact, A.R.S. §§ 32-1668 and -1669, the undersigned parties enter into this Consent Agreement as a final disposition of this matter.

Based on the evidence before it, the Board makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Andrew J. Patterson ("Respondent") holds Registered Nurse License No. RN160122 in the state of Tennessee, a party state to the Nurse Licensure Compact and Respondent's primary state of residence.

2. On or about October 29, 2009, the Board received a complaint from the Vice Chairperson of Nursing Services at Mayo Clinic, alleging that on or about October 26, 2009,

Respondent had exhibited impaired judgment/behavior/substandard nursing practice; failed to administer ordered medications; and accessed the Pyxis machine for medications that were not ordered for his patients. Respondent admitted that he recently was in rehabilitation and refused drug testing, resulting in the termination of his contract at Mayo Clinic Hospital. Based upon the complaint, the Board conducted an investigation.

3. From in or about June 2007 until April 2009, Respondent was employed by Health Providers Choice and assigned to work an assignment at the Mayo Clinic Hospital in Arizona from on or about October 6, 2009 until October 26, 2009.

4. Respondent was scheduled to work the night shift beginning at 7:00 p.m. on October 18, 2009 and ending at 7:00 a.m. on October 19, 2009 at Mayo Clinic Hospital and was responsible for the care of patient F.A.

a. On October 18, 2009, Respondent removed a Metoprolol Tartrate 5mg/5ml vial from the Pyxis for patient F.A. at 2123 and returned the medication to the Pyxis at 2124.

b. On October 18, 2009, Respondent removed a Metoprolol Tartrate 50mg tablet from the Pyxis for patient F.A. at 2125 and returned the medication to the Pyxis at 2129.

c. According to the Pyxis report, at 2129, Respondent returned to the Pyxis a Metoprolol Tartrate 5mg/5ml vial that was documented as given by Fang-Min Liao at 1707.

d. According to the Pyxis report, Respondent removed a Metoprolol Tartrate 5mg/5ml vial at 2130. Respondent documented Metoprolol 5mg IV as given at 2125.

e. According to the Medication Administration Record ("MAR"), Respondent documented giving Metotrolol Tartrate 50mg PO at 2126. According to the Pyxis report, Respondent did not remove this medication from the Pyxis.

5. Respondent was scheduled to work the night shift beginning at 7:00 p.m. on October 25, 2009 and ending at 7:00 a.m. on October 26, 2009 at Mayo Clinic Hospital and was responsible for the care of patient E.S.

a. On October 25, 2009, Respondent documented performing an assessment for patient E.S. at 2333. Respondent failed to document any care on the required flow sheets ("FS"), including the Education FS, Central Cath Line FS and Patient Care Activities FS. The nurse prior to and following Respondent both documented care provided on the flow sheets.

b. On October 25, 2009, patient E.S. was scheduled to receive Rifaxamin 400mg PO at 2200 and Hydrocortisone Succinate 50mg IV at 2200. Respondent failed to administer either medication. The Pyxis report indicates that the medications were not removed from the Pyxis.

c. On October 25, 2009, according to the Pyxis report, Respondent removed a Phenylephrine HCL 10mg vial for patient E.S. at 2247. Patient E.S. had no physician's order for Phenylephrine during her entire stay in the hospital. Respondent failed to account for the medication by either documenting administration or returning the medication to the Pyxis.

d. On October 25, 2009, patient E.S. was scheduled to receive Meropenem 1gm IV at 2100. Although the medication was documented as given, Respondent hung fluconazole at 2100 instead of Meropenem, in error. Respondent fell below the standard of care by not checking the five rights of medication administration; right patient, right medication, right dose, right time and right route.

e. On October 26, 2009, at approximately 0330, Hollie Thornton, RN observed a bag of fluconazole hanging on patient E.S. that was not due to be administered until

0900. Thornton also found the Meropenem had not been administered on October 25, 2009 at 2100 as ordered. According to Thornton and Respondent's documentation, Respondent administered the Meropenem on October 26, 2009 at 0345.

6. Michelle Anderson, RN Critical Care Manager at Mayo Clinic Hospital, provided a written statement regarding her interaction with Respondent on or about October 26, 2009. Anderson met with Respondent in her office at approximately 4:30 a.m., after she had been called at home by the ICU Team Leader, who reported that Respondent was "unable to articulate a full sentence" and had not documented or administered some medications. Anderson noted that Respondent had rapid eye movements, his sentences were poorly structured, and he did not make sense during their conversation. Respondent shared his belief that a patient for whom he was caring was "not really who she says she is" and he explained that "when you live with someone for three weeks you just don't forget who they are in two weeks." Anderson also stated Respondent denied being under the influence of drugs or alcohol, but he allegedly admitted that he just got out of rehab and was in "Sober Living" for three months. According to Anderson, Respondent refused to submit to a urine drug screen, stating he would have one done outside of the facility. He failed to do so.

7. Debbie Sheppard, RN, ICU Team Leader at Mayo Clinic Hospital, provided a written statement regarding her interaction with Respondent on or about October 26, 2009. According to Sheppard, Respondent was observed to have halting speech and was unable to put a complete sentence together. Sheppard described Respondent as "flighty" and "paranoid" and she alleges that Respondent stated, "people are standing outside my room and talking about me" when no one was present. According to Sheppard, when asked to whom Respondent was referring, he replied that "this has been like this for six months." Sheppard reported that

Respondent was not able to articulate what he was talking about. Further investigation revealed that Respondent had neither pulled nor charted medications due at 2100 and 2200 on October 25, 2009. Sheppard opined that Respondent's "ability to take care of his patient was compromised."

8. Cindy McLane, RN, Staff Nurse at Mayo Clinic Hospital provided a written statement regarding her interaction with Respondent on or about October 26, 2009. McLane performed an audit of Respondent's charting on the 12 hour shift beginning October 25, 2009 at 7 p.m. to October 26, 2009 at 7 a.m. and she confirmed the findings set forth in paragraph 5 herein. McLane reported that Respondent said, "I hate it when the gremlins are watching me." During an interview with Board staff on or about April 22, 2010, McLane described Respondent's behavior as "different" and that he appeared "high" but not tired. She stated he made the comment, "There are gremlins on the wall."

9. During an interview with Board staff on or about April 26, 2010, Rosemarie Torrento, CEO, Health Providers Choice reported that she spoke to Respondent telephonically or about October 27, 2009, with Mary Margaret Vaglia, Nurse Recruiter, present. According to Torrento, Respondent was talking "crazy" and informed her that he knew a patient assigned to his care from rehab. When Torrento asked Respondent about rehab he remained incoherent, at which point Torrento ended the conversation. Torrento stated that she called Respondent later in the day, finding him more lucid. Respondent allegedly admitted that he had "fallen off the wagon" and currently was living in a halfway house. When asked to submit a urine drug screen, Respondent refused, stating it would be positive. Torrento stated Respondent also admitted to her that he did not give medications to his assigned patients as ordered.

10. Hollie Thornton, RN, Staff Nurse at Mayo Clinic Hospital, provided a written statement regarding her interaction with Respondent on or about October 26, 2009. At approximately 0330, Thornton found Respondent looking back and forth down the hall from a patient's room. When asked if he needed help, Respondent replied that he needed a "pharmacy bag" to send back a medication that had not been ordered for his patient. Upon further questioning, according to Thornton, Respondent had trouble staying focused and needed redirection and instruction to pull up orders and charts on the computer. Thornton discovered that Respondent had not charted several medications and when she asked him why, he said he "needed to get HPC [his recruiter] on the phone." Respondent seemed frustrated that he could not reach his recruiter at approximately 0400.

11. During the course of the Board's investigation, it was discovered that Respondent had been employed at Memorial Hospital in Chattanooga, Tennessee from on or about June 13, 2005 until April 17, 2009, and that his employment was terminated for sleeping on the job. Respondent is not eligible for rehire.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663 and 32-1664 and the Nurse Licensure Compact, A.R.S. §§ 32-1668 and -1669, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1663(E), as defined in A.R.S. § 32-1601(18)(d) (Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public) and (j) (Violating a rule that is adopted by the board pursuant to this chapter) (effective September 30, 2009); specifically A.A.C. R4-19-403(1) (A pattern of failure to maintain minimum standards of

acceptable and prevailing nursing practice), (7) (Failing to maintain for a patient records that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient), (17) (A pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location) and (31) (Practicing in any other manner that gives the Boards reasonable cause to believe the health of a patient or the public may be harmed) (effective January 31, 2009).

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§ 32-1664(N) and 32-1668 and -1669 to limit, suspend or revoke the multi-state privilege to practice as a professional nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact and Conclusions of Law.

In lieu of a formal hearing on these issues, Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal or judicial review relating to this Order. Respondent further waives any and all claims or causes of action, whether known or unknown, that Respondent may have against the State of Arizona, the Board, its members, officers, employees and/or agents arising out of matters that are the subject of this Consent Agreement and Order.

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Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter. Further, this document shall become a public record upon execution, and the disciplinary action will be reported to the national database NURSYS.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into this Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this Consent Agreement is effective upon its acceptance by the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by the Respondent, the agreement cannot be withdrawn without the Board's approval or by stipulation between the Respondent and the Board's designee. The effective date of this Order is the date the Consent Agreement is signed by the Board and by Respondent. If the Consent Agreement is signed on different dates, the later date is the effective date.

APPROVED AS TO FORM:

Teressa Sanzio, Attorney for Respondent

Dated: 10-24-11

Andrew J. Patterson, Respondent

Dated: 10/24/2011

ARIZONA STATE BOARD OF NURSING

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 11/14/2011

ORDER

In view of the above Findings of Fact and Conclusions of Law and the consent of Respondent, the Board hereby issues the following Order:

A. Respondent's consent to the terms and conditions of the Order and waiver of an administrative hearing is accepted.

B. Respondent's multi-state privilege to practice as a professional nurse in the State of Arizona ("Privilege") is hereby **revoked**; however, the **revocation is stayed** for as long as Respondent remains in compliance with this Order. During the stay of the revocation, **Respondent's Privilege is suspended** for a period of time not to exceed twelve (12) months, pending resolution of disciplinary proceedings against Respondent's Registered Nurse License no. RN160122 by the Tennessee Board of Nursing, and pending formal review by the Board as required in paragraph 5 of this Order.

C. If Respondent is noncompliant with any of the terms of this Order, the stay of the revocation shall be lifted and Respondent's Privilege shall be automatically revoked for a minimum period of five (5) years. The Board or its designee, in its sole discretion, shall determine noncompliance with this Order. Respondent waives any and all rights to any further review, hearing, rehearing or judicial review, or any other causes of action against the Board or the State of Arizona related to any revocation imposed pursuant to this Order.

D. This Order becomes effective upon the Board's and Respondent's acceptance of the Consent Agreement. The effective date of this Order is the date the Consent Agreement is signed by the Board and by Respondent. If the Consent Agreement is signed on different dates, the later date is the effective date.

E. If Respondent is convicted of a felony, Respondent's Privilege shall be automatically revoked for a period of five (5) years. Respondent waives any and all rights to a hearing, rehearing, appeal or judicial review, or any other causes of action against the Board or the State of Arizona related to any revocation imposed pursuant to this Order.

TERMS OF STAYED REVOCATION/SUSPENSION

1. Interview With the Board or Its Designee

Respondent shall appear in person, or telephonically if residing out of state, for interviews with the Board or its designee upon request at various intervals and with at least forty-eight (48) hours notice.

2. Obey All Laws

Respondent shall obey all laws/rules governing the practice of nursing in this state and obey all federal, state and local criminal laws. Respondent shall report to the Board, within ten (10) days, any misdemeanor or felony arrest or conviction.

3. Costs

Respondent shall bear all costs of complying with this Order.

4. Violation of Suspension

Respondent's Privilege is suspended for a period of time not to exceed twelve (12) months, pending resolution of disciplinary proceedings against Respondent's Registered Nurse License no. RN160122 by the Tennessee Board of Nursing, and based upon the Findings of Fact and Conclusions of Law set forth herein. If such disciplinary proceedings do not conclude within twelve (12) months of the effective date of this Order, the stay of the revocation shall be lifted and Respondent's Privilege shall be automatically revoked for a minimum period of five (5) years. The Board or its designee, in its sole discretion, shall determine noncompliance

with this Order. Respondent waives any and all rights to a hearing, rehearing, appeal or judicial review, or any other causes of action against the Board or the State of Arizona related to any revocation imposed pursuant to this Order.

If such disciplinary proceedings conclude within twelve (12) months of the effective date of this Order, and if such proceedings result in a disciplinary Order issued by the Tennessee Board of Nursing restricting or inactivating Respondent's multi-state practice privileges, or if Respondent is accepted into the Tennessee Professional Assistance Program ("TNPAP") in lieu of discipline, then the suspension of Respondent's Privilege shall continue pending receipt by the Board of evidence of successful completion of the Tennessee disciplinary Order or the TNPAP, and pending formal review by the Board as required in paragraph 5 of this Order. If Respondent fails to comply with the Tennessee disciplinary Order in any respect, or fails to successfully complete the TNPAP, the stay of the revocation shall be lifted and Respondent's Privilege shall be automatically revoked for a minimum period of five (5) years. The Board or its designee, in its sole discretion, shall determine noncompliance with this Order. Respondent waives any and all rights to a hearing, rehearing, appeal or judicial review, or any other causes of action against the Board or the State of Arizona related to any revocation imposed pursuant to this Order.

5. Completion of Suspension

Respondent's Privilege is suspended for a period of time not to exceed twelve (12) months, pending resolution of disciplinary proceedings against Respondent's Registered Nurse License no. RN160122 by the Tennessee Board of Nursing, and based upon the Findings of Fact and Conclusions of Law set forth herein. If such disciplinary proceedings conclude within twelve (12) months of the effective date of this Order, and if such proceedings result in

non-disciplinary action or any action leaving Respondent's multi-state practice privileges unrestricted, active and in good-standing (except for acceptance into the TNPAP in lieu of discipline as set forth in paragraph 4), Respondent shall then request, within thirty (30) days of the effective date of the Tennessee Board Order, formal review by the Board of the status of Respondent's Privilege. The request for review must be in writing and shall provide substantial evidence that the basis for the Stayed Revocation/Suspension has been removed and that lifting the suspension of Respondent's Privilege will not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, psychiatric or other evaluations, reports and affidavits regarding Respondent as it deems necessary to make this determination. If Respondent fails to timely request formal review by the Board as required in this paragraph, Respondent's Privilege shall be automatically revoked for a minimum period of five (5) years. The Board or its designee, in its sole discretion, shall determine noncompliance with this Order. Respondent waives any and all rights to a hearing, rehearing, appeal or judicial review, or any other causes of action against the Board or the State of Arizona related to any revocation imposed pursuant to this Order.

6. Voluntary Surrender

Respondent may, at any time this Order is in effect, voluntarily request surrender of his Privilege.

7. Cease and Desist

Respondent shall immediately cease and desist the practice of nursing in the State of Arizona and is not eligible to practice nursing in Arizona under the privilege of any Compact state without prior approval from the Board.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 11/14/2011

COPY emailed in pdf format this 24th day of October, 2011, to:

Teressa Sanzio, PC
Attorney At Law
428 East Thunderbird Road, No. 238
Phoenix, Arizona 85022
tsanziolaw@gmail.com

By: Kim Zack, Assistant Attorney General

COPIES mailed this 28th day of November, 2011, by First Class Mail to:

Teressa Sanzio, PC
Attorney At Law
428 East Thunderbird Road, No. 238
Phoenix, Arizona 85022

By: Llysia Gauntt